BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
FRANK D. LI, M.D.	)	Case No. 800-2016-024505
Physician's and Surgeon's Certificate No. A69092	)	OAH No. 2018041058
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 1, 2018.

IT IS SO ORDERED October 2, 2018.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: FRANK D. LI, M.D., Physician's and Surgeon's Certificate No. A69092, Respondent.	Case No. 800-2016-024505 OAH No. 2018041058

PROPOSED DECISION

Administrative Law Judge Diane Schneider, State of California, Office of Administrative Hearings, heard this matter on August 2, 2018, in Oakland, California.

Supervising Deputy Attorney General Jane Zack Simon represented complainant Kimberly Kirchmeyer, the Executive Director of the Medical Board of California, Department of Consumer Affairs.

Michael J. Khouri, Attorney at Law, Khouri Law Firm, APC, represented respondent Frank D. Li, M.D., who was present.

The record closed and the matter was submitted on August 2, 2018.

FACTUAL FINDINGS

1. On July 1, 1999, the Medical Board of California (California Board) issued Physician's and Surgeon's Certificate No. A69092 (Certificate) to respondent Frank D. Li, M.D. The Certificate was in full force and effect during the events set forth below. Respondent's Certificate expired on January 31, 2017, and is delinquent. Additionally, respondent's Certificate is also suspended, effective August 5, 2016, pursuant to Business and Professions Code section 2310, subdivision (a), based upon the suspension of respondent's medical license in Washington.

2. On April 17, 2018, complainant Kimberly Kirchmeyer, acting in her official capacity as Executive Director of the Board, issued a First Amended Accusation against respondent. The Accusation alleges that respondent's California Certificate is subject to discipline because of actions taken by the Washington Medical Quality Assurance Commission against respondent's license to practice medicine in the State of Washington. Respondent requested a hearing, and this hearing followed.

Action by the Washington Medical Quality Assurance Commission

3. On January 31, 2008, the State of Washington issued to respondent a license to practice as a physician and surgeon. On July 14, 2016,[1] respondent's license was summarily suspended by the Washington Medical Quality Assurance Commission (Washington Commission), due to public safety concerns stemming from respondent's ownership and operation of multiple pain management clinics.

4. On March 28, 2018, the Washington Commission issued a Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order). The Agreed Order resolved the pending statement of charges against respondent.[2] At the time that respondent entered into the Agreed Order, his Washington license had been suspended for over 21 months.

5. The Agreed Order contains over nine pages of factual findings chronicling respondent's provision of dangerously substandard care to patients who suffered from chronic pain. Factual Findings 6 through 8 below summarize the findings contained in the Agreed Order.

6. Respondent is Board-certified in anesthesiology and pain medicine. Respondent was the Medical Director and sole shareholder of the Seattle Pain Center (SPC), which operated eight clinics in the State of Washington. As the owner of the SPC, respondent established office practices, treatment and training. SPC represented itself as a treatment center that employed highly trained practitioners who used best practices to find treatment alternatives to narcotic pain medication. Respondent, however, hired newly licensed mid-level practitioners, such as advanced registered nurse practitioners and physician assistants, to treat patients. Patient records revealed that the clinical practices of respondent and SPC providers repeatedly fell below the standard of care in chronic pain management and the practice of medicine.

7. The Washington Commission investigated respondent's treatment of 18 patients, identified as Patients A through R. The death certificates for 16 of these patients listed acute drug intoxication as a cause or likely contributing cause of death. Respondent

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[1] On the same day, a statement of charges was also filed against respondent.

[2] The Agreed Order also resolved other pending complaints against respondent as well as any future complaints received by the Washington Commission for the same conduct and within the same time period set forth in the Agreed Order.

failed to evaluate the numerous patient deaths and did not have a policy in place for reviewing patient deaths.

8. The medical records for Patients A through R established multiple violations of the standards of care, including:

a. Respondent and SPC providers failed to perform adequate medical examinations and review patients' medical histories and imaging studies to determine if an immediate need existed for opioid therapy.

b. Respondent failed to conduct risk assessments to mitigate patient harm, drug abuse, diversion and addiction; he failed to consider other co-morbidities, including mental health problems, substance abuse and other conditions that contraindicated the use of opioids; and, in prescribing large quantities of opioids, he failed to consider the potential for drug diversion and the risk to public safety. These omissions exposed his patients to multiple risks, including overdose, addiction, and death.

c. Respondent failed to adequately define a treatment plan in which alternative therapies were considered for pain management and referrals were made to other specialists.

d. In spite of repeated evidence of drug abuse or diversion, as reflected by failed urine drug screen tests, requests for early medication refills, inconsistent pill counts, obtaining opioid prescriptions from other providers, and admitted drug misuse, respondent consistently failed to enforce treatment compliance.

e. Respondent failed to hire, train and manage experienced pain management providers, and review patient records for standard of care concerns attributable to his staff and medical providers.

9. The following aggravating factors were noted: The gravity and repeated pattern of unprofessional conduct, which reflected a disregard of patient health and safety for patients A through R, who were highly vulnerable to overdose and death, due to a variety of medical and mental health conditions; the potential for injury, stemming from respondent's practice of hiring inexperienced health care providers, and then failing to train and supervise them; and, his failure to address aberrant behaviors such as drug abuse, drug diversion and overuse of medications. Respondent lacked regard for patients' safety by failing to evaluate SPC practices to help reduce the number of patient deaths.

10. Pursuant to the Agreed Order, respondent's license was suspended for 12 months. (This suspension was in addition to the suspension that respondent had served since July 14, 2016.) In July 2019, and upon his completion of ethics courses, respondent may petition for reinstatement. If respondent's license is reinstated, his license to practice will be placed on probation for 10 years from the effective date of the Agreed Order. If respondent is placed on probation, he must treat his patients within the standard of care and abide by other conditions, including: He is prohibited from practicing as a pain management

physician; respondent may not be involved in pain management centers. Respondent may only practice in the areas of anesthesia and interventional pain management; in so doing, he may only perform procedures that are medically necessary and preauthorized, and he must make a written arrangement with another physician for patients who may require hospital admission after any procedure. Additionally, respondent may not prescribe opioids except for acute pain and for a maximum of seven days with no refills. Respondent must also undergo a competency assessment. Respondent must also submit to practice reviews and report adverse events. Respondent must also register with the Washington Prescription Monitoring Program, successfully complete a prescribing course, and present a paper in which he explains how he intends to apply what he learned about addiction and alternatives to long-term opioid therapy in his medical practice. Respondent may petition to modify (but not terminate) the Agreed Order after five years of full compliance, following the effective date of the Agreed Order. The Washington Commission has the sole discretion to grant or deny respondent's petition for modification.

Respondent's evidence

11. Respondent received his medical degree from the University of North Carolina in 1997. Respondent completed a one-year internship in internal medicine, in 1998, at Pitt County Memorial Hospital. He completed a residency in anesthesiology, in 2001, at the University of California, at Irvine, and a fellowship in pain management in 2002, at the University of California, at Los Angeles. Respondent owned and operated the SPC from 2008 until his license was suspended by the Washington Commission. Respondent also worked in California as a pain management consultant for a medical corporation owned by Lawrence Miller, M.D. According to respondent, Dr. Miller had a contract to provide pain management services to Steven Brourman, M.D., who operated the California Orthopedic and Hand Specialists, in Beverly Hills. Respondent provided consulting services until August 2016, when his Certificate to practice medicine in California was suspended.

12. Respondent explained that in practicing pain management he wanted to treat underserved populations of patients, particularly those who came to him as "high dose" opioid patients, in order to increase their functionality and mitigate the risks involved in taking opioids. Respondent prides himself on being a caring and competent doctor. He regards taking care of patients as a privilege. He agrees with the Washington Commission's goal of reducing the risks involved in opioid treatment. Respondent stated that, through his practice, he was able to reduce large numbers of deaths from opioid abuse and enable many patients to stop using opioids completely.

13. With respect to the Agreed Order, respondent made it clear that he "respects" the decision of the Washington Commission and "intends to follow it." Respondent, however, appears to have two views about his misconduct: On one hand, he stated that he "disagrees" with the Washington Commission's opinion, and settled this disciplinary matter in order to avoid the cost and stress of defending himself; on the other hand, he acknowledges that "hindsight is 20/20" and that he could have "improved his care of patients." Respondent views his suspension period as an "opportunity to reflect on his

practice." He plans to focus on educating himself in order to become more effective in his field.

14. The entire disciplinary process in Washington, from the suspension to losing his pain management clinics, has tremendously impacted respondent. He explained that he experienced denial, depression, and finally, acceptance. Although he did not seek medical treatment for what he describes as "PTSD," he was able to regain stability from the support of his church and family, and by getting a dog.

15. Respondent would like to return to California and practice general medicine, without writing any prescriptions for opioids. He believes that he is competent to treat patients in internal medicine, due to the "overlaps" between pain management and internal medicine. Additionally, he wants to practice in California in order to be closer to his family.

16. In 2017, an investigator with California Board contacted respondent in order to obtain a patient's records from Dr. Miller's office in Beverly Hills. Respondent, who had rendered treatment to the patient, referred the California Board to Dr. Miller's office manager, Jenny Martinez. The investigator contacted respondent several times due to difficulties obtaining the medical records from Dr. Miller's office. Respondent maintained that he "cc'd" Martinez with the investigator's request and called Dr. Miller's office, only to learn that he had moved. Respondent did not follow up by calling Dr. Miller's new office location. Respondent explained that in his view, it was the responsibility of the custodian of records, and not his, to provide the patient's medical records to the California Board. Respondent also expressed surprise that the California Board had not received the medical records from Dr. Miller's office.

17. As of June 28, 2018, respondent's address of record with the California Board was in Beverly Hills. In April 2018, counsel for complainant informed respondent that his address of record was not correct. She told him that he needed to update his address of record to reflect his correct address in Seattle, but he did not do so.

18. Masami Hattori, M.D., is a friend and colleague of respondent's and testified at hearing regarding his impressions of respondent's character and abilities as a physician. Dr. Hattori is Board-certified in pain management and practices in the Bay Area. Dr. Hattori met respondent when they were residents at the University of California, at Irvine. In the years following, they became friends and also consulted with each other regarding their pain management patients. He describes respondent as a "dedicated, caring physician who has done a lot for his patients." Dr. Hattori expressed the utmost confidence in respondent's ability to safely practice as a pain management physician. Although Dr. Hattori was aware that respondent's license to practice medicine had been disciplined by the Washington Commission, he had not reviewed the Agreed Order, and he was not sure of the basis for the discipline.

19. Respondent also submitted letters of support from physicians who are familiar with his work as a pain management physician in Washington. The authors of these letters

describe respondent as a well-trained, hard-working, competent and caring physician. It is noted that a number of the physicians who wrote letters in support of respondent expressed the view that respondent was unfairly targeted by the Washington Commission for political reasons, in order to satisfy the public that officials were taking action to curb opioid abuse, and not because his care was truly substandard.

20. This is respondent's first disciplinary matter before the California Board.

LEGAL CONCLUSIONS

1. The standard of proof applied in making the factual findings set forth above is clear and convincing evidence to a reasonable certainty.

2. Business and Professions Code[3] section 141, subdivision (a), applies generally to licenses issued by agencies that are part of the Department of Consumer Affairs, such as the Board. It provides, in relevant part, as follows:

> For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action by another state . . . for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board.

The disciplinary action of the Washington Commission was based on acts substantially related to the practice of medicine. (Factual Findings 5 through 9.) Accordingly, cause exists under section 141 to take disciplinary action against respondent's Certificate.

3. Section 2305, which applies specifically to licenses issued by the Board, provides in relevant part as follows:

> The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state . . . that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

The findings contained in the Agreed Order, set forth in Factual Findings 5 through 9, constitute cause for disciplinary action in California for unprofessional conduct (§ 2234[4]),

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[3] All references are to the Business and Professions Code unless otherwise indicated.

and for prescribing without appropriate examination (§ 2242, subdivision (a)[5]). Accordingly, cause exists under section 2305 to take disciplinary action against respondent's Certificate.

Disciplinary considerations

4. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Guidelines) (12th ed., 2016), recommends, at a minimum, stayed revocation and five years' probation, subject to appropriate terms and conditions, for respondent's unprofessional conduct under sections 2234 and 2242, subdivision (a). The maximum discipline is revocation. In determining whether or not a licensee is sufficiently rehabilitated to justify continued licensure, it must be kept in mind that, in exercising its licensing functions, protection of the public is the highest priority of the California Board. The California Board seeks to ensure that licensees will, among other things, be completely candid and worthy of the responsibilities they bear by reason of their licensure. The outcome of this case, therefore, turns on whether respondent is rehabilitated to the extent that he can be trusted to practice medicine in a manner consistent with public safety.

At the outset of this analysis, it is noted that respondent has not been previously disciplined by the California Board, and he presented letters from physicians and the testimony from Dr. Hattori, who think highly of him. Respondent's misconduct in the instant case, however, is particularly egregious: He engaged in a pattern of providing substandard patient care as the treating physician and as the Medical Director and owner of eight pain management clinics. Respondent's misconduct evidenced a disregard for patient health and safety, thereby placing many patients at risk of overdose or death. Patients A though R were vulnerable patients when they sought treatment at respondent's clinics; and out of the 18 patients identified in the Agreed Order, the death certificates for 16 of the patients listed acute drug intoxication as a cause or likely contributing cause of death. Respondent remains suspended by the Washington Commission until July 2019, at which time he may apply for reinstatement on probation. In the event the Washington Commission reinstates him, he will be placed on a lengthy period of probation, during which time he will be prohibited from, among other things, practicing as a pain management physician.

Given the nature and extent of respondent's misconduct, in order to remain licensed, respondent must make an extremely strong showing of rehabilitation for the California Board to conclude that he can be trusted to practice safely. It is found that he has failed to meet this heavy burden. Respondent acknowledges the propriety of the action taken by the Washington Commission. He sincerely wishes to resume practicing medicine, a profession he respects,

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[4] Section 2234 authorizes the California Board to take disciplinary action against a licensee for unprofessional conduct.

[5] Section 2242, subdivision (a), provides that prescribing dangerous drugs "without an appropriate prior examination and a medication indication, constitutes unprofessional conduct."

enjoys, and views as a privilege. At the same time, however, it appears that respondent has not fully come to terms with his misconduct. And, as complainant observes, respondent did not present evidence that he has engaged in rehabilitation efforts such as participating in a competency assessment or training, shadowing reputable colleagues, or taking prescribing courses. While respondent asserts that he will cooperate with any terms of probation imposed by the California Board, complaintant correctly observes that respondent's failure to facilitate the production of a patient's medical records, when requested to do so by the California Board, raises fresh concerns regarding his ability or willingness to comply with terms of probation imposed by the California Board. Under these circumstances, protection of the public requires revocation of respondent's Certificate. Respondent may apply for reinstatement of his Certificate three years from the effective date of the Order of revocation imposed in this matter.[6]

ORDER

Physician's and Surgeon's Certificate No. A69092, issued to respondent Frank D. Li, M.D., is revoked.

DATED: August 31, 2018

DocuSigned by:
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for _____
DIANE SCHNEIDER
Administrative Law Judge
Office of Administrative Hearings

[6] See section 2307, subdivision (b).

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **FRANK D. LI, M.D.** 8641 Wilshire Blvd, Suite 200 Beverly Hills, CA 90211 Physician's and Surgeon's Certificate No. A69092, Respondent.	Case No. 800-2016-024505 **FIRST AMENDED ACCUSATION**

The Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California, Department of Consumer Affairs, and brings this First Amended Accusation solely in her official capacity.

2. On July 1, 1999, Physician's and Surgeon's Certificate No. A69092 was issued by the Medical Board of California to Frank D. Li, M.D. (Respondent). The certificate is delinquent, having expired on January 31, 2017, and is SUSPENDED by virtue of an Order issued on August 5, 2016 pursuant to Business and Professions Code section 2310(a).

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JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board) under the authority of the following sections of the California Business and Professions Code (Code) and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
>
> "(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

4. On July 14, 2016, the Washington Medical Quality Assurance Commission (Washington Commission) issued an Ex Parte Order of Summary Suspension regarding

Respondent's license to practice medicine in the State of Washington. The Ex Parte Order of Summary Suspension was based on concerns relating to Respondent's ownership and operation of multiple Seattle Pain Center (SPC) clinics where Respondent and mid-level providers employed by him provided "dangerously substandard care to vulnerable patients suffering from chronic pain conditions". Multiple SPC patients died between 2010-2015, some as a result of acute drug intoxication. The Washington Commission determined that summary suspension of Respondent's Washington license was necessary to address the danger to the public health, safety or welfare. A Statement of Charges was filed.

5. On March 28, 2018, the Washington Commission issued a Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order) to resolve the pending Statement of Charges. A copy of the Agreed Order is attached as Exhibit A.

6. The Agreed Order contains numerous factual findings demonstrating that Respondent failed to prescribe opioids in a safe and responsible manner. Among those factual findings are: Respondent, who is board certified in anesthesiology and pain medicine, acted as medical director and sole shareholder of SPC, which had eight clinic locations in Washington State. Respondent and the SPC providers he hired repeatedly maintained clinical practices that were below the standard of care in chronic pain management and the practice of medicine. Respondent hired newly licensed mid-level practitioners who lacked training or expertise in pain management, and failed to properly train or oversee those providers. He failed to evaluate and investigate numerous patient deaths, or to conduct records reviews for standard of care concerns attributable to his employed staff and providers. A review of 19 patient charts revealed multiple violations of the standard of care. For example, patients were prescribed opioid therapy in the absence of adequate medical examination or objective medical diagnosis. Respondent failed to conduct adequate risk assessments to mitigate patient harm and drug abuse, diversion and addiction, failed to sufficiently consider co-morbidities or risk factors, or to consider the potential for drug diversion and risk to public safety when prescribing high doses or large quantities of opioid medication. Respondent failed to formulate adequate treatment plans, review alternative therapies, or refer to other specialists. He failed to consistently enforce treatment compliance

despite repeated signs of drug abuse or diversion, and continued to prescribe even when notified by other providers of likely drug abuse and potential for patient harm, and in the face of known misuse of medications. A number of patient deaths were attributed, at least in part, to acute drug intoxication as a cause or likely contributing cause of death.

7. At the time of the issuance of the Agreed Order, Respondent's Washington license had been suspended for 21 months. Under the terms of the Agreed Order, Respondent's license was suspended for an additional 12 months. He will be permitted to petition for reinstatement in July 2019, after completing ethics courses. In the event Respondent's Washington license is reinstated, he will be placed on probation for at least 10 years. During probation, Respondent will be prohibited from practicing as a pain management physician, except for interventional pain management or anesthesia. He will not be allowed to be involved in any pain management centers and will be prohibited from supervising, employing or directing any other medical providers. He must undergo a thorough competency assessment, and will only be permitted to prescribe controlled substances for acute pain in a 7 day supply. He will only be permitted to perform interventional pain or anesthetic procedures which are medically necessary and preauthorized, and must make arrangements for any necessary hospital admissions. Respondent will be required to report adverse events and undergo periodic practice reviews. He must utilize the Washington Prescription Monitoring Program, complete a prescribing practices course, and prepare and present a paper emphasizing the principles of addiction and alternatives to long term oral opioid therapy.

8. The Washington Commission noted as aggravating factors the gravity and number of Respondent's acts of unprofessional conduct which demonstrated repeated patterns of substandard care and disregard for patient health and safety, and failure to adequately supervise staff. Respondent's patients were noted to be particularly vulnerable to overdose and death due to medical and mental health conditions. Respondent's practice of hiring newly licensed health care practitioners, inexperienced in pain management, placed his patients at risk for overdose and death, as did his failure to address aberrant behaviors such as medication overuse, signs of drug and alcohol abuse, and signs of drug diversion.

9. Respondent's conduct and the action of the Washington Medical Quality Assurance Commission as set forth above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A69092 issued to respondent Frank D. Li, M.D.;

2. Revoking, suspending or denying approval of Respondent's authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, if placed on probation, to pay the costs of probation monitoring; and

4. Taking such other and further action as the Board deems necessary and proper.

DATED: April 17, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

SF2016201386

EXHIBIT A

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

In the Matter of the License to Practice as a Physician and Surgeon of: **FRANK D. LI, MD** License No. MD00049251 Respondent.	**No. M2016-705** **STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND AGREED ORDER**

The Medical Quality Assurance Commission (Commission), through RICK GLEIN, Commission Staff Attorney, and Respondent, represented by counsel, THOMAS H. FAIN, stipulate and agree to the following. This Agreed Order resolves all cases specifically alleged in the statement of charges (2015-4699 and 2015-4708), all complaints received by the Commission before the entry date (the day of Commission acceptance) of this Agreed Order (2016-8037, 2016-8361, 2016-8366, 2016-8369, 2016-8381, 2016-9182, 2016-12259, 2017-4660, 2017-8957, 2017-10526, and 2018-2378), and any complaints received by the Commission after the entry date which are determined to be of the same conduct within the same period of time set forth in the Findings of Fact and Conclusions of Law.

1. PROCEDURAL STIPULATIONS

1.1 On July 14, 2016, the Commission issued a Statement of Charges against Respondent.

1.2 In the Statement of Charges, the Commission alleges that Respondent violated RCW 18.130.180(1), (4), (7), (13), (14), (22), and WAC 246-919-853, -855, -857, and -860.

1.3 The Commission is prepared to proceed to a hearing on the allegations in the Statement of Charges.

1.4 Respondent has the right to defend against the allegations in the Statement of Charges by presenting evidence at a hearing.

1.5 The Commission has the authority to impose sanctions pursuant to RCW 18.130.160 if the allegations are proven at a hearing.

1.6 The parties agree to resolve this matter by means of this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order).

1.7 Respondent waives the opportunity for a hearing on the Statement of Charges if the Commission accepts this Agreed Order.

1.8 The factual allegations regarding Urine Drug Screening and the alleged violation of fraud are not being adjudicated in this Agreed Order and are being deferred to the attorney general Medicaid Fraud Control Unit. If there is a subsequent conviction, the Commission may take further disciplinary action against Respondent.

1.9 This Agreed Order is not binding unless it is accepted and signed by the Commission.

1.10 If the Commission accepts this Agreed Order, it will be reported to the National Practitioner Data Bank (45 CFR Part 60), the Federation of State Medical Boards' Physician Data Center and elsewhere as required by law.

1.11 This Agreed Order is a public document. It will be placed on the Department of Health's website, disseminated via the Commission's electronic mailing list, and disseminated according to the Uniform Disciplinary Act (Chapter 18.130 RCW). It may be disclosed to the public upon request pursuant to the Public Records Act (Chapter 42.56 RCW). It will remain part of Respondent's file according to the state's records retention law and cannot be expunged.

2. FINDINGS OF FACT

This should be construed as an Alford Plea, wherein Respondent does not admit to the Statement of Charges, but acknowledges that at a hearing before the Commission the State of Washington would present sufficient evidence to prevail on the charges set forth in the Stipulated Findings of Fact, Conclusions of Law and Agreed Order. However the stipulations below shall not be construed as an admission for purposes of any proceeding other than this proceeding. Respondent and the Commission acknowledge that the evidence is sufficient to justify the following findings, and the Commission makes the following findings of fact:

2.1 On January 31, 2008, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent is board certified in anesthesiology. Respondent's license is currently suspended.

2.2 Respondent is board certified in anesthesiology and pain medicine and was the Medical Director and sole shareholder of the Seattle Pain Center (SPC) which had eight (8) clinic locations in Washington State: Seattle; Renton; Everett; Tacoma; Olympia; Spokane; Poulsbo; and Vancouver. SPC represented itself as a pain management treatment center focused on "finding treatment alternatives to narcotic pain medications" by incorporating "emerging best practices." SPC promoted itself as employing five fellowship-trained physicians and mid-level practitioners with Advanced Registered Nurse Practitioner (ARNP) and Physician Assistant (PA) licenses. SPC patient records revealed that Respondent and SPC providers repeatedly maintained clinical practices that were below the standard of care in chronic pain management and the practice of medicine.

2.3 Although SPC was able to hire some mid-level practitioners with experience in pain management, SPC also hired newly licensed mid-level practitioners without training or expertise in pain management. Respondent allowed those newly hired practitioners to treat patients before establishing insurance accreditation.

2.4 As the owner of SPC and employer for all the clinic providers, Respondent established office practices, treatment protocols, and training. The Commission investigated Respondent's treatment of eighteen (18) SPC patients (Patients A through R).

2.5 The death certificates of Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, and R listed acute drug intoxication as a cause or likely contributing cause of death. Patient P died from a vehicle accident, and Patient Q died from a stroke; however, Patients P and Q had multiple serious health conditions that SPC failed to adequately consider during opiate therapy. Patients A through R's medical records reveal a pattern of substandard medical care by Respondent in his individual management of the patient care and as a Medical Director. An unanticipated patient death is a singular, sentinel event requiring immediate critical review for medical and institutional contributions. Respondent did not have a policy in place for morbidity/mortality review.

Inadequate Care of Patients A through R

2.6 SPC patient records reveal multiple violations of the standard of care in the following ways:

2.6.1 Patients A through R, Medicaid enrollees, were referred to SPC for opioid management and had been on opioids prior to the referral, yet Respondent and SPC providers failed to perform adequate independent, thorough medical examinations whereby an objective medical diagnosis was made in determining whether the immediate need for opioid therapy is justified. The providers defaulted to opioid-centric treatment plans at the initial patient visit. SPC providers relied on the patients' subjective complaints and failed to adequately review prior medical histories, imaging studies, and specialty consultations.

2.6.2 Respondent failed to conduct adequate risk assessments utilizing the tools specified by the Interagency Guidelines in order to mitigate patient harm and drug abuse, diversion, and addiction. Respondent failed to sufficiently consider co-morbidities such as mental health problems, prior and current substance abuse, and other physical conditions that contraindicated the use of opioid medication. Failure to adequately consider and address risk factors prior to opioid therapy place patients at serious risks for respiratory depression, overdose, continued addiction, and death. Furthermore, Respondent failed to adequately consider the potential for drug diversion and risk to public safety when prescribing high doses or large quantities of opioid medication.

2.6.3 Respondent failed to adequately define a treatment plan for patients where review of alternative therapies was reconsidered for pain management and referrals were made to other specialists.

2.6.4 Respondent failed to consistently enforce treatment compliance despite repeated evidence of: failed urine drug screen (UDS) tests; requests for early medication refills; inconsistent pill counts; obtaining opioids from other providers; and admitted drug misuse. Under Respondent's oversight as the Medical Director, SPC providers issued "aberrancy" findings of non-compliance, yet there was no consistent enforcement whereby medications were withheld or the patient discharged from the practice. Compliance was monitored with multiple UDS tests, and results were infrequently reviewed with the patients.

Patients A, D, I, and R

2.7 Patients A, D, I, and R were treated by SPC providers under Respondent's management as a Medical Director. As a Medical Director, Respondent was responsible for establishing protocols to ensure safe effective patient care and to ensure that SPC providers complied with the established protocols. He also had the duty to perform quality assurance reviews and develop policies and procedures, including: training of clinic staff, evaluating and monitoring the quality of patient care, and identifying and correcting deficiencies. As SPC Medical Director, Respondent failed to hire and properly train experienced pain management providers. He also failed to evaluate and investigate patient deaths, and he failed to conduct records reviews for standard of care concerns attributable to his employed staff and providers.

Patient B

2.8 Patient B, a 35-year-old woman and homemaker who had a history of cocaine overdose and mental health issues, died on January 25, 2010. The death certificate listed the cause of death as acute methadone intoxication. Just three days prior, Respondent prescribed Patient B methadone and Norco.

Patient C

2.9 Patient C, a 50-year-old man, died on January 15, 2012, from a heart attack. However, a toxicology report revealed diazepam, methadone, and tetrahydrocannabinol (THC) in Patient C's blood. Patient C obtained treatment at SPC seven times from March 2011 through January 2012. Respondent saw the patient in May 2011. Subsequent SPC providers prescribed increasing methadone doses of 30 mg to 40 mg daily even after Patient C admitted to taking more pills than prescribed, had a history of overdose, and continued to smoke medical marijuana. Respondent evaluated the patient and failed to adequately act on aberrancies in the record, such as inconsistent UDS.

Patient E

2.10 Patient E, a 60-year-old man living in a residential care facility, was last treated by Respondent in August 2010, and last treated by a PA that Respondent supervised in April 2011. Patient E died on August 4, 2011. The death certificate listed the cause of death as acute methadone intoxication. SPC medical records dated April

18, 2011, document that Patient E had an office visit for a "medication refill" and received a letter of discharge for violating his opioid agreement.

2.11 SPC medical records document Patient E's prior drug overdoses and hospitalizations, drug diversion, and illegal buying of prescription drugs, although Patient E did have a valid pain condition due to multiple medical conditions. A PA, supervised by Respondent, regularly prescribed to Patient E oxycodone, Ambien, clonazepam, and Fentanyl patches. Two months prior to his last office visit, Patient E's primary care provider informed SPC that oxycodone and Fentanyl patch doses caused breathing difficulties for Patient E. The provider also referenced a written recommendation from the hospitalist to decrease Patient E's opioid dose because of a recent hospitalization for drug overdose.

Patient F

2.12 Patient F, a 42-year-old woman, was treated by Respondent in December 2010. Patient F died on December 28, 2011. The death certificate listed the cause of death as acute combined morphine, diphenhydramine, and citalopram intoxication. Not all of these medications were prescribed by Respondent or SPC providers. Patient F had eight total SPC visits between November 2010 and December 2011, and medical records document a history of depression and requests for increased opiate doses, early refills, and use of illegal substances. On December 20, 2011, SPC issued a letter of discharge, as well as prescription refills for Klonopin and MS Contin (morphine) even though her UDS was negative for morphine.

Patient G

2.13 Patient G, a 46-year-old woman, was last seen by a PA supervised by Respondent on February 5, 2013. Patient G died on February 20, 2013. The death certificate lists the cause of death as acute drug intoxication due to the combined effects of methadone, hydromorphone, nortriptyline, and Citalopram. SPC providers prescribed methadone and hydromorphone. The medical examiner also noted a probable contributory factor of cardiovascular disease.

2.14 Patient G was last seen by Respondent in November of 2012 for an epidural steroid injection, was under the care of Respondent and a PA supervised by Respondent, and for over two years the PA prescribed multiple opioids without evidence

of reduced pain or functional improvement. Patient G had vague complaints of back and leg pain, experienced failed treatment by her primary care provider and the University of Washington pain clinic, and showed little improvement after a series of six spinal injections. Patient G had multiple high risk factors for opiate abuse: repeated complaints of insufficient pain treatment requiring escalating opioid doses; inconsistent UDS; self-treatment with alcohol and medical marijuana; history of major depression, anxiety, alcohol abuse and dependency; history of incarceration; and psychiatric disorders requiring hospitalization. She also suffered from multiple physical health co-morbidities which contraindicated the on-going use of chronic opiates: hepatitis, cirrhosis (secondary to alcohol abuse), asthma, obesity, and seizures.

2.15 Despite Patient G's risk factors and known medication misuse, the PA prescribed methadone, Norco, Dilaudid, and morphine, often at more than 400 morphine equivalent dose (MED). The PA and Respondent failed to exercise more stringent monitoring of Patient G's medication compliance. There is no documented attempt to establish an opioid exit strategy despite Patient G's repeated drug-seeking behaviors and indicators of severe over-sedation. There is no documentation revealing Respondent's concerns about the PA's prescribing and management of Patient G.

Patient H

2.16 Patient H, a 55-year-old paraplegic woman, was seen by Respondent in December 2010 and subsequently by a PA supervised by Respondent. Patient H died on May 15, 2011. The death certificate lists the cause of death as acute drug intoxication due to the combined effects of morphine, oxycodone, diazepam, trazodone, and gabapentin. SPC providers prescribed MS Contin and oxycodone. Patient H suffered from multiple conditions including chronic obstructive pulmonary disorder (COPD), opioid dependence, and chronic pain. She also had a history of hospitalizations for respiratory failure. Patient H had four SPC office visits where Respondent and a PA he supervised prescribed increasing doses of MS Contin and oxycodone at each visit while being aware of Patient H's high risk factors for opioid misuse. At Patient H's last office visit on May 13, 2011, the UDS showed benzodiazepines not prescribed by SPC. However, the results of the UDS were not available until May 19, 2011. The PA prescribed MS Contin 30 mg TID (three times a

day) and oxycodone 30 mg TID (225 MED). This increase was thought to be reasonable according to Respondent because "the long-acting component was raised to 90 MED and we knew that she was able tolerate MED of 105 from 3-17-11 to 5-13-11. The strategy was to increase her short-acting component so that she could have more control over how much she needed above the baseline amount, and refrain from taking them if not needed or tolerated. Because most of the increase was in the short acting, as-needed component, it was thought to be tolerable."

Patient J

2.17 Patient J, a 58-year-old woman, was found dead on April 7, 2013. The death certificate lists the cause of death as acute drug intoxication due to the combined effects of methadone, hydromorphone, tramadol, and trazodone. Between September 2012 and January 2013, Patient J had four SPC office visits where she obtained opioid therapy. Patient J was treated by a PA supervised by Respondent.

Patient K

2.18 Patient K, a 54-year-old woman, died at home on March 11, 2013. The death certificate lists the cause of death as acute drug intoxication (alprazolam) and additive drug effects (carisprodol, hydrocodone, and meprobamate). Patient K had mental health risk factors and prior hospitalizations for overdose. She received pain infusion at SPC. Respondent failed to recognize the documentation in the record that indicated Patient K's DAST (Drug Abuse Screening Test) score was consistently elevated, indicating a moderate level of problems related to drug abuse that required further investigation, which was not adequately performed.

Patient L

2.19 Patient L, a 62-year-old man, died at home on January 30, 2015. The death certificate lists the cause of death as bronchopneumonia with pulmonary abscesses and emphysema. Acute opiate intoxication was listed as a contributing condition. Patient L died 15 days after filling his last prescription for methadone, oxycodone, and morphine at more than 1,500 MED. Respondent states that Patient L began a "2 year wean of one pill per day reduction per month" at SPC in April 2014. Respondent further states that Patient L's death was "NOT [sic] the direct result" of the opioid medications because SPC had decreased the doses consistently and gradually.

Patient M

2.20 Patient M, a 36-year-old man, died at the hospital on July 26, 2011. The death certificate lists the cause of death as acute intoxication of the combined effects of methadone, citalopram, trazodone and valproic acid. SPC providers prescribed methadone and morphine. Other conditions contributing to death were listed as chronic pain syndrome, schizoaffective disorder, and fatty liver disease. Patient M began opioid therapy at SPC in February 2011 when he obtained morphine prescriptions. Patient M had schizoaffective disorder, a history of physical and emotional abuse, hyperlipidemia, and chronic pain. Respondent failed to adequately control high risk factors for opioid abuse and misuse, and in less than six months Patient M was switched from morphine to an escalated dose of prescribed methadone. Patient M also had a documented failed UDS and documentation of misusing medications prior to receiving methadone prescriptions.

Patient N

2.21 Patient N, a 51-year-old man, was last treated by Respondent in May 2011. Patient N died on July 1, 2012, from acute combined hydrocodone, hydromorphone, and methadone intoxication, four days after filling his last prescriptions for these medications. Patient N had multiple high risk factors for medication abuse and misuse: prior substance abuse; bipolar disorder; attention deficit hyperactivity disorder; taking non-prescribed opioids; and history of sexual/physical abuse. SPC providers documented multiple aberrant behaviors of drug-seeking, but deemed the conduct as not egregious and maintained Patient N on escalating opioid doses.

Patient O

2.22 Patient O, a 28-year-old woman, died on January 12, 2011. The death certificate lists the cause of death as acute combined hydrocodone, hydromorphone, and methadone intoxication. Patient O filled her final methadone prescription from SPC just five days prior to her death.

2.23 Patient O had complaints of knee pain, and Respondent initiated a dose of morphine at 75 MED daily. Patient O had 11 SPC office visits over a one-year period, and she also obtained prescriptions for oxycodone, Norco, and methadone. Patient O was morbidly obese, ambulated with crutches, and continued to rate her pain level as

high even while using opioids. She had a history of significant mental health risk factors (depression and history of abuse), thus she was prone to suffer from chronic pain as a somatic manifestation of emotional suffering. Respondent did not attribute her pain to psychosomatic chronic pain that can occur in patients with significant histories of childhood abuse. Patient O's multiple UDSs were also positive for THC and once for cocaine, and negative for prescribed opioids. Respondent's continued opioid prescribing in light of Patient O's comorbidities and illicit drug use posed serious risks of medication abuse.

2.24 Respondent documented Patient O's request for early medication refills as "evidence of inadequate pain control," and does not provide an early refill of requested oxycodone; instead, Respondent prescribed additional opioids, methadone, and Dilaudid. Treating musculoskeletal knee pain with methadone may be considered below the standard of care especially when high risk factors are indicated.

2.25 Patient O's multiple aberrancies were also indicative of drug misuse and potential diversion, yet Respondent failed to cease opiate therapy or take greater control over the patient's access to pain mediation by prescribing fewer dosage units in a single prescription or similar action.

Patient P

2.26 Patient P was seen by Respondent on one occasion in December 2012. Patient P was a 58-year-old man who died on May 3, 2013, from injuries sustained when his vehicle veered over a highway median and collided head-on with a logging truck. A scene investigation revealed a malt liquor can wedged between Patient P's leg and the gearshift. State toxicology report indicates the presence of ethanol, oxycodone, and tricyclic antidepressants in Patient P's blood. Patient P's death occurred 19 days after filling his final prescription from SPC for oxycodone.

2.27 Respondent, a PA he supervised, and other SPC providers treated Patient P's chronic pain by prescribing oxycodone at 180 MED for greater than two years without sufficient evidence of improvement. Patient P's referring provider requested a detailed independent medical evaluation of Patient P's severe post traumatic headaches, but SPC failed to adequately perform this. Patient P was maintained on an oxycodone regimen at his request, and there was no documented objective diagnosis or

risk assessments. Patient P had depression, hypertension, and history of stroke. He took more medication than prescribed and requested early refills. Respondent did not enforce the need to avoid alcohol during opiate therapy. The two UDSs performed were positive for the presence of alcohol. Respondent and SPC providers failed to implement an opioid exit strategy knowing that concurrent alcohol use potentiates opioid side effects.

Patient Q

2.28 Patient Q, a 54-year-old man, died on May 24, 2014, from hemorrhagic cerebral infarct (stroke). Between March 2012 and May 2014, Respondent, a PA supervised by Respondent, and SPC providers prescribed escalating monthly doses of oxycodone HCL and OxyContin. Patient Q displayed repeated aberrant behaviors, such as inconsistent UDS results and taking more medication than prescribed, yet SPC providers maintained an oxycodone therapy regimen without adequately addressing Patient Q's two years of non-compliant medication use. SPC providers failed to adjust Patient Q's opiate therapy given his serious health conditions including the need for open heart surgery just six months prior to death.

Seattle Pain Center Clinical and Business Practices

2.29 Respondent on occasion hired ARNPs and PAs with little to no experience or training in treating chronic noncancer pain. In fact, these mid-level providers joined SPC by relying on Respondent's agreement to provide training in chronic pain treatment. SPC also on occasion hired mid-level providers recently graduated from clinical school and allowed these providers to treat patients and bill for services before obtaining an established National Provider Identifier (NPI) number or insurance credential.

2.30 In 2013, Respondent hired an experienced pain management PA for the Spokane clinic. Respondent allowed the PA to treat patients and bill for services for several months prior to submission of a delegation agreement to the Commission. Once notified of this requirement, the PA ceased treating patients until the delegation agreement was in place.

2.31 In 2013, the Washington State Department of Labor and Industries (L&I) denied Respondent's application to renew his provider contract. L&I's decision was

based on complaints of noncompliant opioid prescribing practices and an SPC PA's alleged substandard care of an injured worker who eventually died from drug overdose. Respondent withdrew his application.

3. CONCLUSIONS OF LAW

The Commission and Respondent agree to the entry of the following Conclusions of Law.

3.1 The Commission has jurisdiction over Respondent and over the subject matter of this proceeding.

3.2 Respondent has committed unprofessional conduct in violation of RCW 18.130.180(1), (4), (7), (14), (22), and WAC 246-919-853, -855, -857, and -860.

3.3 The above violations provide grounds for imposing sanctions under RCW 18.130.160.

4. AGREED ORDER

Based on the Findings of Fact and Conclusions of Law, Respondent agrees to entry of the following Agreed Order.

4.1 **Suspension of Respondent's License.** Respondent's license has been suspended for a period of **twenty-one (21) months**, beginning July 14, 2016. Respondent's license is SUSPENDED for an additional **twelve (12) months** following entry of this Agreed Order.

4.2 **Petition for Reinstatement.** Respondent may petition for reinstatement in July 2019, and after fulfilling the following requirements:

4.2.1 **Ethics Courses.** Respondent shall enroll in and successfully complete both the 2.5-day Professional/Problem Based Ethics (ProBE) course and the in-depth follow-up six-month course, the ProBE Plus Program, offered by the Center for Personalized Education for Physicians (CPEP). (http://www.cpepdoc.org/cpep-courses/probe-ethics-boundaries-program-united-states). To satisfy this provision, Respondent must obtain an "unconditional pass" at the conclusion of each course. Respondent will permit CPEP to communicate with the Commission regarding his participation in the courses and will provide the Commission a copy of the essays the Respondent writes as part of the courses. A failure by the Respondent to obtain an "unconditional pass" upon completion of

either coursework may result in the Commission requiring Respondent to re-take the course. Respondent will submit proof of the successful completion of each course to the Commission within **thirty (30) days** to the Compliance Officer at addresses listed below:

1. Medical.compliance@doh.wa.gov

2. Compliance Officer
   Medical Quality Assurance Commission
   P.O. Box 47866
   Olympia, WA 98504-7866

4.3 **Probation Following Reinstatement.** Following the Commission's granting of reinstatement of Respondent's license, the Commission will place Respondent's license on PROBATION. Respondent's license to practice as a physician and surgeon in the state of Washington is subject to this Agreed Order for a period of at least **ten (10) years** from the effective date of this Agreed Order. Respondent must fully comply with all of the terms and conditions set forth in this Agreed Order and Respondent's treatment of his patients must meet the standard of care.

4.4 **Practice Conditions.** Subsequent to the Commission's granting of reinstatement of Respondent's license, Respondent must comply with the following conditions:

4.4.1 **Restriction on Clinical Patient Care.** Respondent is RESTRICTED from practicing as a pain management consulting physician per WAC 246-919-860. Respondent is restricted from providing any pain management consultations outside of interventional pain management or anesthesia for the duration of this Agreed Order.

4.4.2 **Restricted from Acting as a Medical Director.** Respondent is RESTRICTED from performing in any way as an owner, operator, medical director, manager and/or supervisor of any pain management center(s). Respondent is further restricted from having a majority interest in any type of diagnostic or biological specimen testing laboratory center and may not refer his patients for lab work to a lab in which he has a financial interest for the duration of this Agreed Order.

4.4.3 **Restricted from Supervising Medical Providers.** Respondent is RESTRICTED from employing, overseeing, or directing any other medical providers, i.e., physicians, physician assistants, or nurse practitioners for the duration of this Agreed Order.

4.4.4 **Practice Restriction.** Respondent's license is RESTRICTED and he may only practice in the areas of anesthesia and interventional pain management under the requirements set forth below.

4.4.5 **Competency Assessment.** Within **thirty (30) days** of reinstatement of Respondent's license, Respondent will enroll in a thorough competency assessment which must be pre-approved by the Commission's Medical Consultant. Completion of the evaluation must be accomplished within **sixty (60) days** of reinstatement of Respondent's license. The Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego School of Medicine is pre-approved.

4.4.5.1 Respondent must contract with PACE to conduct a complete and thorough competency assessment. The assessment must include screening examinations, including at a minimum history and physical, cognitive, and psychological screening. The assessment must also include reviews of Respondent's:

- actions which resulted in this case;
- responses to his patients' negative outcomes;
- reasoning and decision making;
- knowledge and understanding of controlled substances, especially methadone and other narcotics, including his knowledge of the appropriate use of controlled substances, their risks alone and in combination, and how to document decision making when prescribing controlled substances;
- ability to create meaningful and appropriate medical records and evaluate the medical records of his patients' other health care providers; and
- ability to identify his knowledge gaps and implement appropriate responses to any such areas of deficiency.

4.4.5.2 Respondent must provide PACE with any release for information that is requested and must unconditionally cooperate with PACE during the evaluation. Respondent must sign a waiver of confidentiality and a release to permit PACE and the Commission to share information. The Commission will provide PACE with records from the Commission's files that the Commission deems appropriate.

4.4.5.3 Respondent must authorize PACE to provide a comprehensive written report, including any third-party evaluation reports, to the Commission. Respondent must ensure that PACE provides its report to the Commission.

4.4.5.4 Respondent must follow all recommendations in PACE's evaluation report, including recommendations for educational and other remediation, medical or other treatment, the use of a preceptor, additional evaluations indicated by the assessment's screening examinations, and re-assessment after completion of remediation. Respondent agrees that the recommendations will be incorporated into a modified Commission Order.

4.4.5.5 Proof of enrollment, evaluation, and completion of the program shall be sent to the Compliance Unit at the addresses listed in paragraph 4.2.1.

4.4.6 **Limitation on Prescribing Controlled Substances.** Respondent may prescribe oral pain medication for acute pain management and provide up to a 7-day supply of such oral pain medication with no refills. (See CDC and AMDG guidelines.) Respondent shall not prescribe opioids except for acute pain as described above. **Respondent shall not hire or direct anyone else to prescribe opioids for his patients.**

4.4.7 **Commission Approval of Practice Site.** Prior to resuming practice after Respondent's reinstatement in paragraph 4.2 above, Respondent's worksite must be pre-approved by the Commission or its designee.

4.4.8 **Restrictions to Interventional Pain Practice.** Respondent is restricted from performing any interventional pain or anesthetic procedures which

are not medically necessary. Respondent shall obtain at least telephonic preauthorization for any proposed interventional pain or anesthetic procedures from a Physician Reviewer pre-approved by the Commission or Commission's designee. The Physician Reviewer must be a physician who has an active unrestricted license and who is Board certified by the American Board of Anesthesiology, The American Board of Psychiatry and The American Board of Neurology, or the American Board of Physical Medicine and Rehabilitation. The Physician Reviewer shall be paid for by Respondent. The case presentation to the Physician Reviewer shall include:

- A thoroughly documented reason the intervention is requested.
- Documentation of a thorough and complete medical examination.
- A documented discussion with the patient of alternative treatments.
- Documented informed consent to the procedure. Informed consent shall include providing a copy of this Agreed Order to the patient or describing the facts and conditions of the Agreed Order in an informed consent form to be pre-approved by the Commission.

Post-procedure documentation shall include, but not be limited to, a description of the patient's improved function or improvement/worsening of conditions after the procedure. The Commission retains the ability to obtain Respondent's patient billing records for analysis by the Physician Reviewer. The charts of the patients for whom interventions were performed will be reviewed quarterly by the Physician Reviewer who will submit quarterly reports to the Compliance Officer at the addresses listed in paragraph 4.2.1. The ultimate decision as to whether a procedure was medically necessary is reserved for the Commission. At its sole discretion, the Commission may modify the preauthorization requirement in paragraph 4.4.8 at any time upon the Commission's satisfaction that reviewed procedures have been medically necessary and appropriate and preauthorization is no longer necessary in view of continuing quarterly reviews.

4.4.9 **Hospital Admissions.** Respondent shall make arrangements with a physician who has hospital admitting privileges in the city where any interventional pain procedure is performed to assist with admitting any patient who requires

hospital admission during or after any procedure. Respondent's arrangement with the admitting physician shall be reduced to writing, and Respondent shall provide the agreement to the Compliance Officer at the addresses listed in paragraph 4.2.1.

4.4.10 **Reporting of Adverse Events.** Respondent must report to the Commission and Physician Reviewer any adverse events including, but not limited to, death, infection, or unanticipated hospitalization of any patient.

4.4.11 **Notice to Employer.** Respondent must provide a copy of this Agreed Order to his health care employer and ensure that the employer understands the Commission decision in this case. Within seven (7) days of the start of employment, Respondent will cause his employer to inform the Commission, in writing, of the employer's knowledge of this Agreed Order.

4.5 **Practice Reviews.** In order to monitor compliance with this Agreed Order, Respondent will submit to periodic practice reviews performed by an entity pre-approved by the Commission or its designee. The Physician Enhancement Program (PEP), through the PACE program referenced in paragraph 4.4.5, is pre-approved. Respondent is responsible for all costs associated with the practice monitoring program. The program will include, but is not limited to, the following components:

- The representative will review the PMP for Respondent to ensure he is in compliance with the prescribing limitation in paragraph 4.4.6.
- The representative will conduct an on-site visit, including but not limited to a site assessment, longitudinal chart review, interview, patient visit observation, and a site visit every six months for the duration of the program.
- The representative and Respondent will jointly create a Personal and Practice Development Plan (PPDP) to educate Respondent on the process of self-managed continuous quality improvement and objectively measure the results.
- The representative will conduct a monthly chart audit, and Respondent will engage in a monthly phone call to discuss progress on documentation, quality of care, and the PPDP.
- The representative will provide the Compliance Officer listed in paragraph 4.2.1 with brief summary reports on a monthly basis and a detailed report

summarizing progress in the program and further recommendations on a quarterly basis.

- Respondent will participate in a Physicians Universal Leadership Skills Education (PULSE) survey after initial enrollment and after approximately six months to measure improvement.

Respondent will maintain waivers of confidentiality authorizing full exchange of information between the evaluator, the practice review entity, and the Commission. The Commission may take additional action, in a separate case, if the practice review reveals ongoing concerns regarding Respondent's practice.

4.6 **Compliance Orientation.** Respondent shall complete a compliance orientation in person or by telephone within **sixty (60) days** of the effective date of this Agreed Order. Respondent must contact the Compliance Unit at the Commission by calling (360) 236-2763, or by sending an email to: Medical.compliance@doh.wa.gov within ten (10) days of the effective date of this Agreed Order. Respondent must provide a contact phone number where Respondent can be reached for scheduling purposes.

4.7 **Prescription Monitoring Program (PMP).** Within **thirty (30) days** of reinstatement, Respondent will register with the Washington Prescription Monitoring Program (PMP), if he has not already done so. Respondent will query the PMP regularly for all patients that he prescribes controlled substances for under the terms of paragraph 4.4.6. Respondent will document the PMP query in the patient's medical record, and will note any evidence of aberrant behavior.

4.8 **Prescribing Course.** Within **twelve (12) months** of the effective date of this Agreed Order, Respondent shall take and successfully complete one of the following courses:

A. The "Intensive Course in Controlled Substance Prescribing," at Case Western Reserve University in Cleveland, Ohio, (216) 983-1239. (https://case.edu/medicine/cme/courses-activities/intensive-course-series/controlled-substance).

B. "Prescribing Controlled Drugs," at Vanderbilt University Medical Center, Center for Professional Health, Nashville, Tennessee, (615) 936-0678. (https://ww2.mc.vanderbilt.edu/cph/36620).

C. "The Physician Prescribing Course," at the University of California, San Diego School of Medicine, (619) 543-6770. (http://www.paceprogram.ucsd.edu/CPD/Prescribing.aspx).

Respondent shall submit proof of the completion of the CME hours within **thirteen (13) months** of the effective date of this Agreed Order to the Compliance Officer listed in paragraph 4.2.1. The course shall not count towards the credits required to maintain licensure.

4.9 **Paper.** Following completion of the course required in paragraph 4.8, Respondent must prepare and submit a typewritten paper to the Commission. The paper must be a minimum of two thousand (2,000) words, contain a bibliography, refer to the course completed in paragraph 4.8, and state how Respondent intends to apply what he learned in his practice, with a specific emphasis on principles of addiction and alternatives to long-term oral opioid therapy. The paper must be submitted within **three (3) months** after completing the related course pursuant to paragraph 4.8. Respondent should be prepared to discuss the subject matter of the written paper with the Commission at his next personal appearance. The paper must be submitted to the Commission in both electronic and printed format to the Compliance Officer listed in paragraph 4.2.1.

4.10 **Peer Group Presentation.** Respondent shall organize and present his paper to a peer group with interest in pain management. Proof of completion, attendance, and materials must be submitted to the Compliance Officer listed in paragraph 4.2.1.

4.11 **Personal Appearances.** Respondent must personally appear at a date and location determined by the Commission in approximately **six (6) months** after reinstatement, or as soon thereafter as the Commission's schedule permits. Thereafter, Respondent must make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. Respondent must participate in a brief telephone call with the Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over Respondent's compliance with the requirements of this Agreed Order. The Commission will provide reasonable notice of all scheduled appearances.

4.12 **Pain Management Rules.** Respondent will fully comply with the pain management rules, found at WAC 246-919-850 through 863.

4.13 **Fine.** The Commission has waived a direct fine requirement from Respondent given his contemplated large financial settlement with other persons and entities impacted by his conduct described in the Findings of Fact.

4.14 **Modification.** Respondent may petition in writing for modification of this Agreed Order after **five (5) years** of full compliance following the effective date of this Agreed Order. The Commission will have sole discretion to grant or deny Respondent's petition. Respondent may petition for modification, but not for termination.

4.15 **Obey all laws.** Respondent shall obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

4.16 **Compliance Costs.** Respondent is responsible for all costs of complying with this Agreed Order.

4.17 **Violation of Order.** If Respondent violates any provision of this Agreed Order in any respect, the Commission may initiate further action against Respondent's license up to and including revocation of his license.

4.18 **Change of Address.** Respondent shall inform the Commission and the Adjudicative Clerk Office, in writing, of changes in Respondent's residential and/or business address within thirty (30) days of the change.

4.19 **Effective Date of Order.** The effective date of this Agreed Order is the date the Adjudicative Clerk Office places the signed Agreed Order into the U.S. mail. If required, Respondent shall not submit any fees or compliance documents until after the effective date of this Agreed Order.

4.20 **Termination.** Respondent may not petition to terminate the terms and conditions of this Agreed Order until at least **ten (10) years** after the effective date of this Agreed Order. When Respondent files such a petition, a date and time will be arranged for Respondent's appearance before the Commission, unless the Commission waives the need for Respondent's personal appearance. The Commission will have sole discretion to grant or deny Respondent's petition.

5. COMPLIANCE WITH SANCTION RULES

5.1 The Commission applies WAC 246-16-800, *et seq.*, to determine appropriate sanctions. Tier C of the "Practice Below Standard of Care" schedule, WAC 246-16-810, applies to cases where substandard practices caused severe harm or death

to a human patient. Respondent's violation of the standard of care was severe because Patients A through R were in vulnerable states when they sought treatment from Respondent's clinics. It is clear that the substandard care provided by Respondent, both in his individual capacity and in his failure to oversee the clinic operations as a Medical Director, caused severe harm to Patients A through R. Respondent's failure to adequately supervise his multiple clinic sites, failure to consider and address risk factors prior to placing Patients A through R on opioid therapy, and failure to properly respond to red flags in continuing opioid therapy for Patients A through R fell below the standard of care. In addition to Patients A through R, there were other patients identified in the cases listed in the introductory paragraph who were not specifically included in the Findings of Fact section.

5.2 Tier C requires the imposition of sanctions ranging from three years to permanent oversight. Under WAC 246-16-800(3)(d), the starting point for the duration of the sanctions is the middle of the range; however there is no middle range for Tier C. WAC 246-16-800(3)(c) directs the Commission to identify aggravating or mitigating factors to determine appropriate sanctions.

MITIGATING FACTORS:

- Respondent has not been the subject of prior discipline with the Commission.

AGGRAVATING FACTORS:

- The gravity and number of Respondent's acts of unprofessional conduct. Medical records obtained for Patients A through R show repeated patterns of substandard care and disregard for patient health and safety, and failure to adequately supervise his staff.
- The vulnerability of Patients A through R. Patients A through R were highly vulnerable to overdose and death due to the various medical conditions and mental health conditions documented in the medical records.
- Potential for injury to be caused by the unprofessional conduct. Respondent's practice of hiring newly licensed health care practitioners, inexperienced in pain management, placed his patients at risk for overdose and death. The risk continued with Respondent's failure to address aberrant behaviors, such as:

overusing medications, history or documented signs of drug and alcohol abuse, and signs of drug diversion through aberrant UDSs.

- Insufficient regard for patient safety. Respondent displayed insufficient regard for patient health and safety despite the number of patient deaths suffered in his patient population. Respondent has not produced documentation to indicate that he initiated an evaluation or investigation of SPC practices to help reduce the number of SPC patient fatalities.
- Respondent had ultimate responsibility in his capacity as Medical Director for the patient care provided by the SPC clinics. Respondent held out his clinics to other providers as specialty care for pain management patients and acted as the Medical Director for eight clinics across the state. However, he failed to properly supervise and train the mid-level staff who performed the majority of patient assessments and management.

5.3 The gravity of the aggravating factors over the one mitigating factor supports the imposition of a ten-year oversight period. The sanctions in this case include a three (3) year suspension, probation for ten (10) years with license restriction, two ethics courses, a clinical competency assessment and clinical education program, and practice conditions for a five-year period with the ability to modify the Agreed Order after five (5) years at the Commission's discretion. Sanctions also include: quarterly practice reviews, annual compliance appearances before the Commission, a course on opioids and addiction training, a paper, and a presentation. These sanctions are appropriate within the C range given the facts of the case and the extreme volume and weight of the aggravating factors over the mitigating factor.

6. FAILURE TO COMPLY

Protection of the public requires practice under the terms and conditions imposed in this order. Failure to comply with the terms and conditions of this order may result in suspension of the license after a show cause hearing. If Respondent fails to comply with the terms and conditions of this order, the Commission may hold a hearing to require Respondent to show cause why the license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under

RCW 18.130.180(9). In either case, Respondent will be afforded notice and an opportunity for a hearing on the issue of non-compliance.

7. RESPONDENT'S ACCEPTANCE

I, FRANK D. LI, Respondent, have read, understand and agree to this Agreed Order. This Agreed Order may be presented to the Commission without my appearance. I understand that I will receive a signed copy if the Commission accepts this Agreed Order.

FRANK D. LI, MD
RESPONDENT

3/23/18
DATE

THOMAS H. FAIN, WSBA# 7117
ATTORNEY FOR RESPONDENT

3/24/18
DATE

8. COMMISSION'S ACCEPTANCE AND ORDER

The Commission accepts and enters this Stipulated Findings of Fact, Conclusions of Law, and Agreed Order.

DATED: March 28, 2018.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE
COMMISSION

PANEL CHAIR

PRESENTED BY:

RICK GLEIN, WSBA # 23692
COMMISSION STAFF ATTORNEY